READ THIS FIRST

USE THESE INSTRUCTIONS TO HELP YOU FILL OUT THE ATTACHED MEDI-CAL ANNUAL REDETERMINATION FORM (Please return this form to your county welfare department)

1. ***PRINT*** all answers in ink (black ink is best).
2. Please note the following:

   "Applicant" means: (a) you, if you are applying for yourself and/or your family; or (b) the person you are filling in this form for (including the person in long-term care).

   "Caretaker" means a relative other than a parent who is applying on behalf of children under 21 years. A caretaker may ask to be included in the children's Medi-Cal case.

   "Family Member" means: (a) you, even if you are a single person; (b) your spouse or other parent of the children, living with you; (c) your children under 21 years, who are living with you or are away at school; (d) your spouse's or other parent's children under 21 years, who are living with you or are away at school; (e) your unborn child.
3. If you need help or have any questions, ***ask your worker.***
4. If you need more space to answer any question, or have additional information to report, use ***question 21.***

State of California—Health and Human Services Agency Department of Health Services

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MC 210 RV (8/99) INSTRUCTION SHEET

MEDI-CAL ANNUAL REDETERMINATION

Do you want your Medi-Cal benefits to continue? ❒ YES ❒ NO If no, sign and date the last page of this form. If yes, you must answer all of the following questions.

ADULT FAMILY MEMBERS

1 Applicant or Caretaker's Name (First, Middle, Last) | Applicant/Caretaker Relationship to Children

Social Security Number	Marital Status (check one)	Sex
	❒ Married (Date)_____ ❒ Never married ❒ Common law ❒ Separated (Date) _____ ❒ Widowed ❒ Divorced	❒ Female ❒ Male

Is Person Working?	Is the Person Blind, Disabled or Incapacitated?	Pregnant	Medi-Cal Requested
❒ Yes ❒ No	❒ Yes, Date of Disability:_____ ❒ No	❒ Yes ❒ No	❒ Yes ❒ No

2 Home Address (Number and Street) | City | ZIP Code

Mailing Address (If different from above) | City | ZIP Code

Area Code and Home Phone	Area Code and Work Phone	Area Code and Message Phone	Person With Whom to Leave Message:
( )	( )	( )	

3 Spouse/Other Parent (First, Middle, Last) | Relationship to Applicant

Social Security Number	Marital Status (check one)	Sex
	❒ Married (Date)_____ ❒ Never married ❒ Common law ❒ Separated (Date) _____ ❒ Widowed ❒ Divorced	❒ Female ❒ Male

Is Person Working?	Is the Person Blind, Disabled or Incapacitated?	Pregnant	Medi-Cal Requested
❒ Yes ❒ No	❒ Yes, Date of Disability:_____ ❒ No	❒ Yes ❒ No	❒ Yes ❒ No

COUNTY USE ONLY

Case name: _____

_____

Case Number: _____

Worker Number: _____

Date: _____

CHILDREN AND OTHER ADULTS IN HOUSEHOLD

4 LIST ALL CHILDREN AND OTHER ADULTS LIVING IN YOUR HOUSEHOLD:

Name	Relationship	Date of Birth	Pregnant? Yes	Pregnant? No	Student Yes	Student No	Medi-Cal Requested Yes	Medi-Cal Requested No	Linkage	FSD Referral	Sneede

LIVING ARRANGEMENT IN-KIND

5 Do you or any family member:

a. Pay for an apartment or house? Amount $_____ ..... ❒ Yes ❒ No

b. Get free housing, utilities, food, or clothing? ..... ❒ Yes ❒ No

c. Work in exchange for housing, utilities, food, or clothing? ..... ❒ Yes ❒ No

If b or c are "yes," answer all the following questions:

What was received?	Who received it?	Who provided it?

❒ MC 210 SI

TAX DEPENDENT

6 Are you or any family member claimed as a tax dependent by a person not living with you? ❒ Yes ❒ No

Name and address of person claiming the tax deduction: _____

_____

RESIDENCY

7 Has anyone changed immigration/citizenship status in the last 12 months? ❒ Yes ❒ No

Who: _____ Alien number:_____

What changed:_____ Date:_____

❒ MC 13

DED

8 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs? ❒ Yes ❒ No

Who: _____

❒ DED packet

❒ DED Re-exam date_____

HEALTH INSURANCE

9 Do you or any family member have health insurance? ❒ Yes ❒ No

Who is insured? _____

Did you or any family member get new health, dental, or Medicare coverage or insurance? ❒ Yes ❒ No

❒ DHS 6155 form given

EMPLOYMENT

10 Attach a copy of the three most recent wage stubs for each person who is working.

Person Number 1—Name | Gross Monthly Earnings $

Employer | Work Telephone ( ) | Date Employment Began (If New Job) ____/____/____

Address (Number and Street) | City | State | ZIP Code

Hours Worked Per Week | Hours Worked Per Month | ❒ Paid Weekly ❒ Every Two Weeks ❒ Two Times a Month ❒ Other | Income From Tips $

Person Number 2—Name | Gross Monthly Earnings $

Employer | Work Telephone ( ) | Date Employment Began (If New Job) ____/____/____

Address (Number and Street) | City | State | ZIP Code

Hours Worked Per Week | Hours Worked Per Month | ❒ Paid Weekly ❒ Every Two Weeks ❒ Two Times a Month ❒ Other | Income From Tips $

Person Number 3—Name | Gross Monthly Earnings $

Employer | Work Telephone ( ) | Date Employment Began (If New Job) ____/____/____

Address (Number and Street) | City | State | ZIP Code

Hours Worked Per Week | Hours Worked Per Month | ❒ Paid Weekly ❒ Every Two Weeks ❒ Two Times a Month ❒ Other | Income From Tips $

11 If any family member is self-employed, attach a copy of last federal tax return or profit/loss statement.

Adjusted gross income from last federal tax return: $ _____ Has income changed? ❒ Yes ❒ No

BUSINESS

12 a. Business/self employment checking/savings accounts or cash? ❒ Yes ❒ No

b. Business equipment, vehicles, tools, inventory, or materials (including livestock or poultry not for personal use):

_____

c. Type of equipment: _____

OTHER INCOME

13 Do you, the other parent/spouse, or children living in the home receive any other income? ❒ Yes ❒ No

If yes, list the source and amount of income received each month. If income is received less often than monthly, indicate how often received. Attach proof of this income.

Source of Income	Applicant	Spouse	Child
Social Security or Railroad Retirement	$	$	$
SSI/SSP	$	$	$
Veterans Benefits (including Aid and Attendance payments)	$	$	$
Retirement or Pension	$	$	$
Interest Income or Dividends	$	$	$
Contributions (including those from relatives)	$	$	$
Child and Spousal Support	$	$	$
Unemployment	$	$	$
State Disability	$	$	$
Worker's Compensation	$	$	$
CalWORKS	$	$	$
Other (describe)	$	$	$

OTHER EXPENSES

14 Does anyone who works pay for care of a child or disabled adult? ❒ Yes ❒ No

If yes, please complete the following (attach receipts):

Name of Person Receiving Care	Age of Person Receiving Care	Amount of Payment	How Often Paid
Person 1			
Person 2			
Person 3			

Who do you pay for the care? _____
Name

_____
Address

15 Does anyone pay court-ordered child or spousal support? ❒ Yes ❒ No Amount $_____

16 Is anyone receiving school grants or loans? ❒ Yes ❒ No Who?_____

COUNTY USE ONLY

❒ Wage Stubs
❒ If U-Parent, MC 210 SW
❒ Student exemption
❒ Wage Stubs
❒ If U-Parent, MC 210 SW
❒ Student exemption
❒ Wage Stubs
❒ If U-Parent, MC 210 SW
❒ Student exemption
❒ Profit/loss statement
$ _____
$ _____
❒ Verifications
❒ Temporary
❒ Permanent
❒ Receipts
❒ Court order
❒ Verified actual payment
❒ MC 210 SE

LIQUID RESOURCES

17 List all resources you, the other parent/spouse, or children living in the home have, or resources held or kept for you by anyone.

a. Cash or uncashed checks: Amount $ _____

b. List all savings or checking accounts in banks, savings and loans, credit unions, IRA, KEOGH, deferred compensation, retirement accounts, annuities, stocks, bonds, certificates of deposit, or money market or mutual fund accounts:

Financial Institution	Type of Account	Account Number	Value/Balance

COUNTY USE ONLY

❒ Copies of accounts

REAL AND PERSONAL PROPERTY

18 a. List real property you own in any country, state, or county (land you own, have title to, or share title in).

ITEMS: houses, land, apartments, mobile homes taxed as real property, or other. If new property, attach a copy of escrow papers and tax statement.

Address or description of property: _____

_____

Value of new property: $ _____ Amount owed: $_____ Monthly payment: $_____

b. Address or description of property that you no longer own: _____

Did you sell this property? ❒ Yes ❒ No If yes: when?_____ Value of property sold $ _____

Did you give this property to someone? ❒ Yes ❒ No If yes: who did you give it to? _____

If you sold or gave away property, attach proof.

c. List all life insurance policies, burial plans, burial plots, crypts, or vaults:_____

_____

Face value of any life insurance policies, burial plans, burial plots, crypts, or vaults: $_____

❒ Exempt? ❒ Yes ❒ No

❒ Escrow papers

❒ Sold

❒ Given away

❒ CSV

VEHICLES

19 List all cars, trucks, campers, motor homes, motorcycles, airplanes, boats, trailers, or off-road vehicles (even if not running) owned by you or your family. Attach copies of vehicle registrations. If none, write "none."

Make and Model	VIN	Year	Owner	Amount Owed	Used for Transportation? Yes	No

❒ Exempt? ❒ Yes ❒ No

❒ Vehicle registrations

❒ Registered class

SERVICES

20 a. Do you want information for Child Health and Disability Prevention Program (CHDP) health services for children under 21? ❒ Yes ❒ No

b. Do you want information on the special supplemental program for Women, Infants, and Children (WIC) for pregnant or breastfeeding women and children under 5? ❒ Yes ❒ No

❒ CHDP brochure/referral

❒ WIC referral

ADDITIONAL INFORMATION

21 Additional information: (List any additional information for questions 1 through 20.)

_____

_____

_____

_____

CERTIFICATION

- I have read and received a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and/or any family members if I/we claim to be in a satisfactory immigration status. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/our family's eligibility and share-of-cost level, if any, are correct.

It is the responsibility of the applicant/beneficiary and person acting for the applicant/beneficiary to report to the Eligibility Worker within ten (10) days any changes that occur.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts and any of its supplemental form(s) that I may be asked to complete is true and correct.

Signature of Applicant		Date
Signature of Witness, Interpreter, or Person Assisting	Telephone Number ( )	Date
EW Signature		Date